

Service Development Plan for Specialist Health Adult Learning Disability Services

Staffordshire and Stoke-on- Trent
2013-2016

Final Draft September 2013

Principles for Future Specialist Health Adult Learning Disability Services

- *Adults with Learning Disabilities will be supported to meet +their health needs in order for them to lead fulfilling lives as full members of the community.*
- *Adults with Learning Disabilities will be supported to access mainstream NHS services in a timely manner, delivered in a person-centred way.*
- *Where Adults with Learning Disabilities need to access specialist health services, these will be focussed on developing and maintaining inclusion.*
- *Adults with Learning Disabilities will be supported to meet their health needs by the most appropriate health or social care professional.*
- *Specialist learning disability health services will respond to service user needs and develop responsive services.*
- *Specialist learning disability health services will promote safe, person-centred support and evidence based-practice.*
- *High quality services will be delivered with flexibility to be able to respond to changing health needs, personal priorities and national directives.*
- *Specialist learning disability health services will utilise outcome measures to ensure continuous service evaluation and development*

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Introduction

This service development plan is for specialist health adult learning disability services and is provided to inform both local Commissioners and Providers of adult learning disability services in Staffordshire and Stoke-on-Trent. A 'plain English' version of the service development plan will complement this with the aim of reaching other audiences such as service users, carers, family and advocates.

The service development plan across Staffordshire and Stoke-on-Trent outlines a tiered service model for Specialist Health Adult Learning Disability Services. This model will ensure that the role and function of all elements of the service are clear and that they work effectively together to enhance the experience of Adults with Learning Disabilities, who present with additional complex needs and/or challenging behaviour.

The tiered model includes tiers of service that will be provided by social care providers, whether statutory services such as social care assessment and care management teams or services commissioned by local authorities and provided by the independent or voluntary sectors.

Staffordshire and Stoke-on-Trent presents challenges in providing a universal model of service delivery. Therefore, although services across both the City and County will be working within the tiered structure and framework, it is anticipated that there may be some variations in service models at the point of delivery.

The service development plan for Staffordshire and Stoke-on-Trent Specialist Health Adult Learning Disability Services will help people with learning disabilities, their carers and partner agencies to understand what we do and what we have to offer as a specialist Adult Learning Disability Health service. It will ensure continued partnership working to improve existing services and to develop innovative services to meet the changing needs of people with learning disabilities with complex needs and/or challenging behaviour. It will also help to define the roles to be played in the support of people with complex needs and challenging behaviour by the NHS and by social care providers.

The service development plan is also key to ensuring the services meet the needs of people in Staffordshire and Stoke-on-Trent and the standards and expectations of a modern integrated service.

There has been agreement by all stakeholders of the need for a coherent plan for Specialist Adult Learning Disability Health services in Staffordshire and Stoke-on-Trent. The service development plan is supported by:

- Stafford and Surrounds Clinical Commissioning Group (CCG)
- East Staffordshire CCG
- South East Staffordshire and Siesdon CCG
- Cannock Chase CCG
- North Staffordshire CCG
- Stoke on Trent CCG
- Staffordshire County Council
- Stoke-on-Trent City Council
- South Staffordshire and Shropshire Healthcare NHS Foundation Trust
- North Staffordshire Combined Healthcare NHS Trust
- Stoke-on-Trent and Staffordshire Learning Disability Partnership Boards (LDPB).

There is substantial agreement on the key themes outlined in the 'context' documented in this plan, and a commitment to defining the best service models.

Although this plan relates to the specialist health service model, it is acknowledged that social care will have a significant role in its delivery. Therefore, this document should be read in conjunction with the existing strategies for the support of people with a learning disability in Staffordshire and in Stoke on Trent. Therefore, this document should be read in conjunction with the existing strategies for the support of people with a learning disability in Staffordshire and in Stoke on Trent.

Context

The National Development Team for inclusion (NDTi) was commissioned by NHS and local government Commissioners for Staffordshire and Stoke on Trent to review specialist Adult Learning Disability health services across the two areas. The Commissioners recognised the need for a review of the strategic approach to these services. The brief was to review current services against policy and best practice models and provide recommendations for future services to the previous Primary Care Trusts (PCT) Commissioners, now CCG's.

The Commissioners requested that the review had a particular focus upon services to people labelled as challenging and /or who have the most complex needs i.e. those in greatest needs of specialist NHS input and who are likely to prove most costly to services. Although the remit of the NDTi was to look at NHS commissioned and provided services, it was apparent that the role played by social care was also critical to the on-going support for this client group. The report's recommendations included points about future integration of health and social care services and were based on the view that the whole local health and social care economy relating to people with learning disabilities had to change to improve outcomes.

The report recommended that “a substantial and medium term programme of organisational change” was essential if local services were to deliver policy expectations and also avoid increasing costs, ensuring high quality services for the future.

The key recommendations of the NDTi report were:

- A joint approach by health and social care commissioners that incorporates specialist health services and continuing care in order to create shared financial and outcome incentives that improve the competence and capacity of local services to support PLD with health needs , including as they relate to behaviour that challenges services.
- The engagement by NHS providers in the delivery of that strategy as their strategic priority.

- A refocusing of NHS resources away from bed based services into more preventative, responsive and joined up community based supports that operate in partnership with social care providers.
- The creation of staff and system resources to lead effective person centred life planning and service development for people with the most complex needs in order to help develop local resources and services.
- New, partnership based working arrangements for health and social care professionals across both authority areas.
- Effective and informed strategic oversight of the improvement process and service delivery by Learning Disability Partnership Boards and senior managers.

The review and subsequent report also identified three major issues to be addressed as a priority; 'strategic vision and direction', 'evidence based practice', 'service model'.

In addition to the NDTi report and recommendations, the final report from the Department of Health (December 2012) regarding Winterbourne View Hospital has recommendations that need to be included in this strategy for Staffordshire and Stoke-on-Trent Learning Disability services.

The Winterbourne View Report 'Transforming Care' has set out a programme of action to transform services so that 'vulnerable people' no longer live inappropriately in hospitals and are cared for in line with best practice based on their individual needs. 'Vulnerable people' in this report refer to children, young people and adults with learning disabilities or autism, who also have mental health conditions or challenging behaviour.

The main elements of the programme of action are:

- Commissioning the right local services
- National leadership to support change
- Strengthening accountability and corporate responsibility in providers

- Tightening regulation and inspection
- Improvements to safety and care delivery
- Monitoring and reporting

The Winterbourne View Report 'Transforming Care' contained a number of recommendations designed to ensure that similar incidents do not occur in the future. These included:

- A requirement that all NHS funded placements in similar establishments to Winterbourne View were reviewed by June 2013
- Clear direction that the expectation should be that such hospital placements are used for a small minority of people with complex needs and that community based support close to the person's home should be the first option considered
- Clear direction that people with a learning disability should not be placed in long stay NHS services to receive support
- A deadline to find alternative community based placements for people currently in hospital placements by June 2014.

The key recommendations for CCG's also include dramatically reducing the number of hospital placements, maintenance of a register of people, closure of large hospitals and review of all NHS funded placements in similar establishments to Winterbourne View, by June 2013.

Within the report there are also specific work-streams for Commissioners, Providers, Regulators, Safeguarding bodies and the wider systems; all who have a responsibility to demonstrate they are providing high safe and quality care.

Service Development Framework

Tiered Service Model

What is the Tiered Service Model?

The Tiered Service Model provides a framework to help describe what can often be complicated needs across multiple areas of health care, and offers a way of conceptualising and mapping the health needs of people with learning disabilities.

All people with learning disabilities have everyday health needs, just like anyone else. Using this tiered model, services provided at Tier 1 and 2 include primary care and mainstream health services which should be accessible to people with Learning Disabilities. Mainstream services should be able to make reasonable adjustments to allow this. Although there is a role here in Tier 1 and 2 services for specialist health learning disability teams, its role here is to support mainstream services, raise awareness of the needs of people with learning disabilities and to facilitate appropriate access.

Some people with learning disabilities have additional health needs that will require more specialist assessment, treatment, and support from very specialist health services, found at tier 3 and 4. This service development plan relates to those specialist health services at tier 3 and 4.

Services at Tier 3 (see diagram) consist of an Integrated Specialist Community Learning Disability Health Team (CLDT). They provide support for people that require longer term specialist support to meet their health needs appropriately and safely.

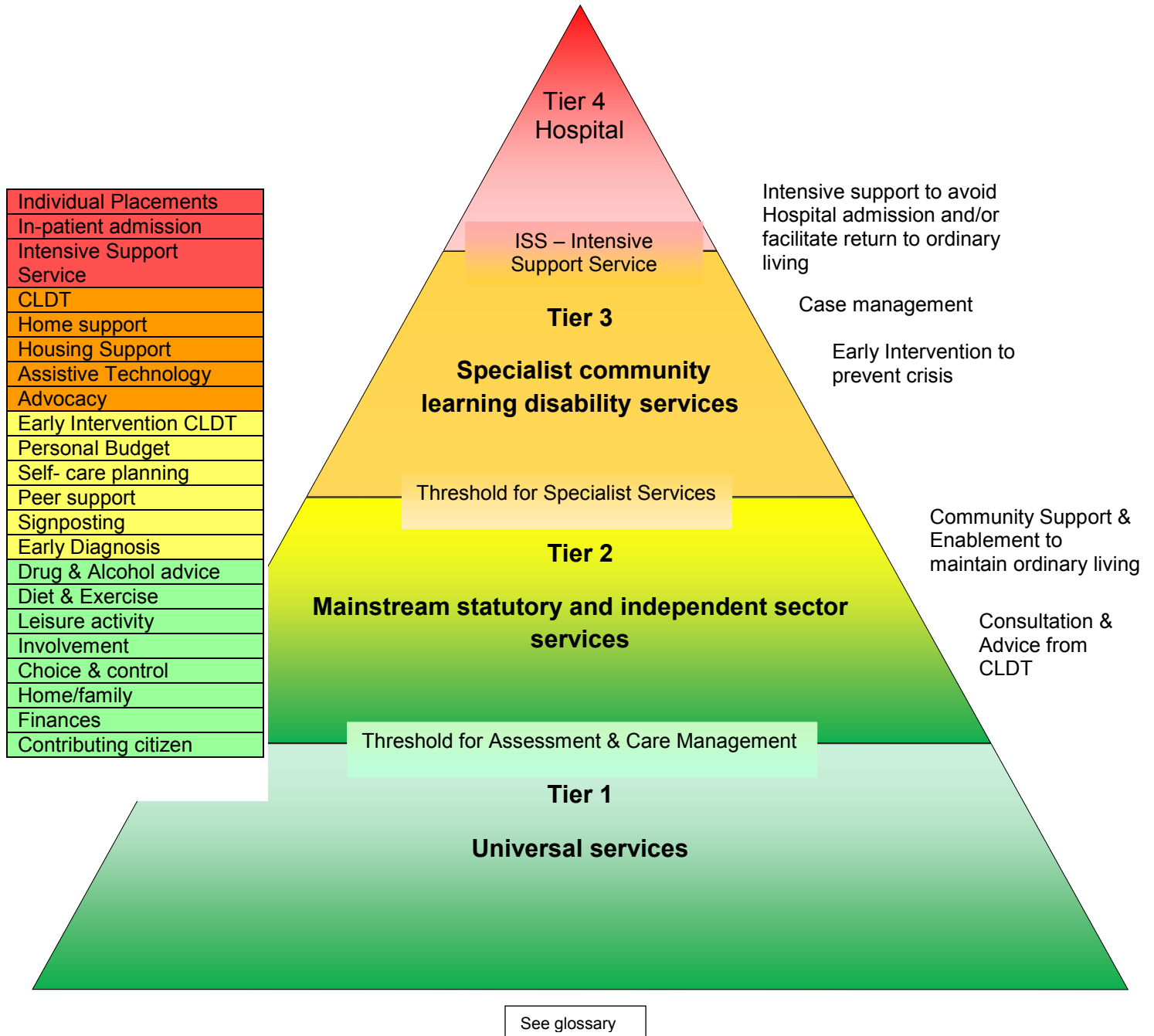
Tier 4 services consist of very specialist health support, either in the community or in bed based services for shorter term planned and emergency assessment, treatment and interventions for people with Learning Disability presenting with more complex difficulties or high levels of risk that present challenges to mainstream services.

Social Care:

Specialist health teams at tier 3 and 4 are fully integrated between health and social care. This will ensure that health and social care needs are met simultaneously and in a person-centred and timely manner.

In addition there social care services may be required to provide complementary support for people with learning disabilities and complex challenging behaviour/needs.

Tiered Service Model



The diagram below demonstrates how the services will interlink and how an individual with a learning disability may move in and out of different aspects of the learning disability service as a whole.

The specialist assessment, treatment and support service has two elements; a community pathway and an inpatient pathway. The inpatient provision will consist of a small number of assessment and treatment beds and a more medium term rehabilitation provision.

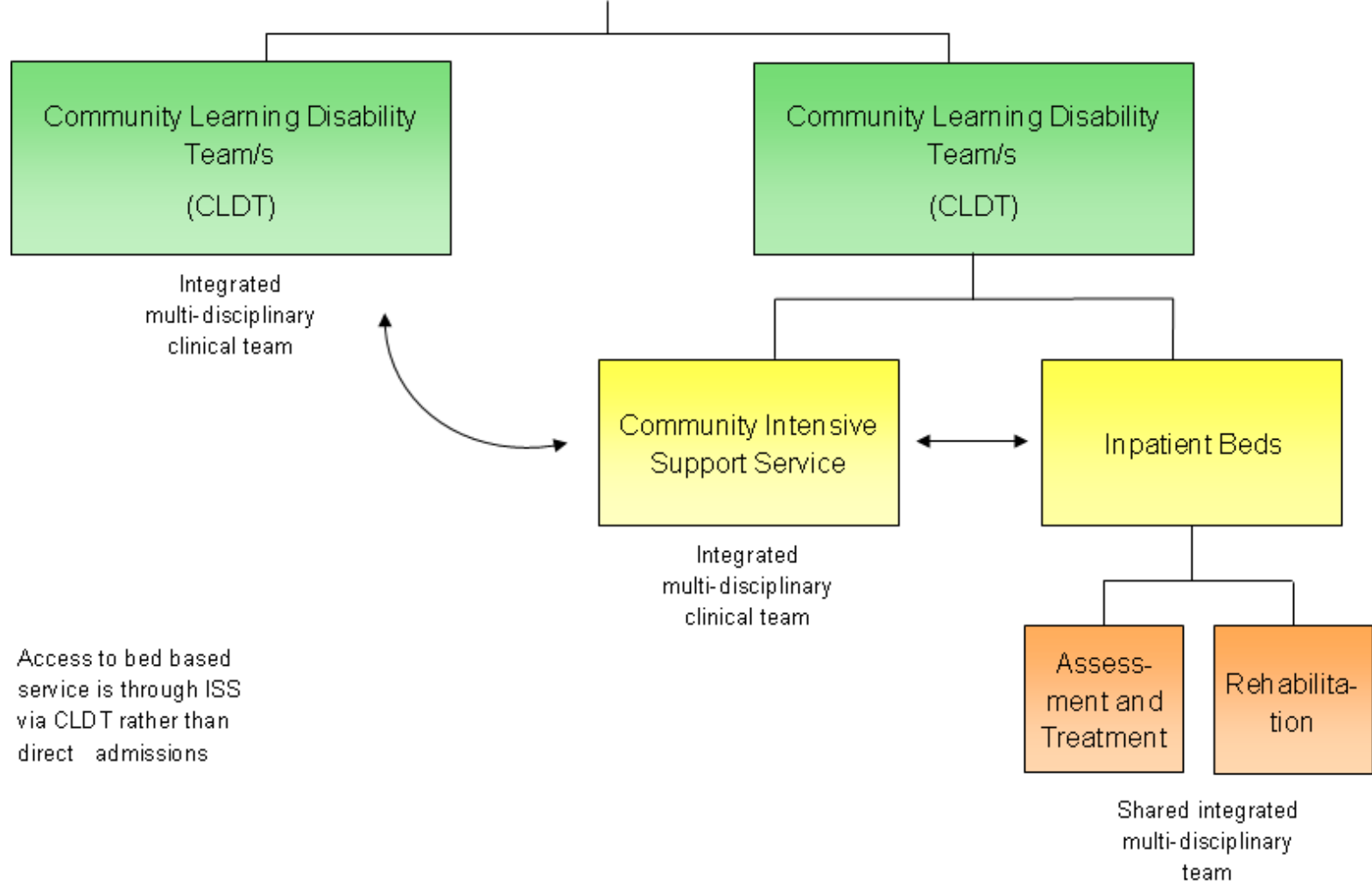
The community pathway of the assessment and treatment service is the Intensive Support Service (ISS), which acts as a gate keeper for access to beds in the inpatient service and also links to the Integrated Community Learning Disability Team (CLDT) as the next level in the tiered service model.

The arrows illustrate the pathway that someone with a learning disability might follow, moving in and out of the CLDT and ISS seamlessly, according to increasing support needs at times of crisis and moving back to CLDT for longer term support when the crisis has been managed.

This is replicated in the movement between the ISS and inpatient beds showing how someone with a learning disability may be supported by the ISS both pre-admission and post-discharge, for a period of inpatient stay in a bed based service.

In this model the ISS is shown as sitting as part of the specialist assessment treatment and support service rather than under the Tier 3 CLDT.

Specialist Adult Learning Disability



Future Model for Learning Disability Teams and Services in Staffordshire and Stoke-on-Trent.

The services outlined below are provided for anyone aged 18 years or more with a diagnosed learning disability; according to the additional admission criteria for each service. Young people making the transition from children's to adults' services at aged 17 years will be considered eligible on an individual case basis, according to need.

Within the tiered model of service delivery, the specialist learning disability health services will be operating at Tier 3 and Tier 4 level.

At Tier 2 members of the specialist learning disability teams may offer information, advice and guidance to mainstream services, statutory and independent sectors, to enable people with learning disabilities to access their appropriate local services thus minimising the need for support from specialist services.

The specialist learning disability services in Staffordshire and Stoke-on-Trent will consist of both health and social care professionals and will feature the following:

Tier 3 services - Specialist Community Learning Disability Services

- Integrated Community Learning Disability Teams

The ISS actually sits between Tier 3 and Tier 4, to enable individuals to access seamless support.

Tier 4 services – inpatient services

- Assessment and treatment service
- Rehabilitation

Additional information regarding these services and their access criteria can be found in the appendices.

1. Tier 3 services - Specialist Community Learning Disability services

- ***Integrated Community Learning Disability Teams (CLDT's)***

Integrated CLDT's provide time limited, person-centred assessment, care management, care co-ordination, therapeutic intervention and health professional training and support for people with learning disabilities, living in the community in a range of settings.

The team should be fully integrated and multidisciplinary consisting of community learning disability nurses, some with specific specialities, AHP's such as Occupational Therapy, Speech and Language Therapy, Physiotherapy, Dietetics and also Psychology and Psychological therapists, Social Workers and Psychiatry.

The team provides specialist assessments and interventions to maximise potential and promote independence in the community through education, equipping an individual with a range of coping strategies, practical support to increase meaningful activity and education regarding health needs.

The team also takes a role in case management for those individuals placed in out of area placements and for those individuals presenting with complex and on-going needs associated with complex learning disabilities and /or behaviour that challenges services.

Some AHP services may be accessed from primary care, although they are learning disability specialist services.

2. Intensive Support Service (ISS)

The ISS provides an integrated responsive highly specialist assessment, treatment and support service for people with complex learning disabilities and behaviour that challenges; providing support in a range of community based settings or to support discharge from in-patient services; for those individuals' with on-going complex challenging behaviour that may increase risks during transition and impact on the success of the discharge.

The ISS offers time limited support and interventions from a fully integrated multi-disciplinary clinical team.

The aim of the ISS is to avoid hospital admissions by providing a high quality specialist community service.

3. Tier 4 services – inpatient services

Assessment and Treatment

Inpatient services will offer a small number of bed based services in an assessment and treatment unit that will offer a time limited short period of specific assessment and treatment delivered by multi-disciplinary and integrated teams; to support people with Learning Disabilities experiencing episodic acute health care needs

The service operates a time-limited provision, with a maximum stay of six months to ensure and enable individuals move back to a placement within the community.

Individuals must require emergency health care due to the breakdown of their ordinary community placement as a result of experiencing acute health care needs in relation to:

1. Severe and frequent behaviour which challenges.
2. Acute mental health needs.
3. Requiring short/medium term assessment and/or treatment under the Mental Health Act, but not requiring intensive supervision or security.
4. Requiring intensive assessment, observation and treatment in relation to epilepsy

The assessment and treatment service is for the group of individuals who in addition to their learning disability or as a result of their learning disability have complex health care needs, that necessitates the need for regular and frequent physical nursing interventions or a need for Registered Learning Disability nursing interventions to manage their challenging behaviour.

Every individual will have a clear discharge plan from the point of admission, with the outcome aiming for the individual to return to the locality. The individual may be supported pre and / or post admission via the ISS.

On occasion in-patient beds within other acute services such as Mental Health for example, may be utilised according to clinical need, presentation and identified risks. Clear pathways agreed with services such as Mental Health will facilitate this.

Rehabilitation

Inpatient services will also offer medium term rehabilitation for individuals with mild / moderate learning disability over the age of 18 years presenting with enduring levels of challenging behaviour that requires a period of rehabilitation.

During a period of rehabilitation an individual will be case managed by the local integrated community learning disability team, to ensure seamless transition back to the community when required. This will then avoid lengthy inappropriate periods of admission. Discharge planning will commence at the point of admission to facilitate this.

Additional support:

Whilst accessing any part of the specialist health learning disability services, the people with learning disabilities and their carers/ family can expect that their allocated social care team/ worker will remain with them throughout their care pathway.

Additional support from further specialist health adult learning disability services such as Clinical Nurse Specialist Learning Disability (health facilitators) can be accessed via appropriate referral routes when required by the people with learning disabilities and their family/carers or other members of the specialist health learning disability teams/ services as appropriate. Referral to other agencies may also be made if necessary.

Quality Monitoring of Services

The principles of high quality services for people with learning disabilities with complex needs and challenging behaviour are services that are individualised and person-centred, provided locally by a skilled integrated workforce, improve quality of care and quality of life and are good value for money.

People with learning disabilities with complex needs and challenging behaviour and their carers can expect to receive the support they need in the most appropriate setting when they need it.

In Staffordshire and Stoke-on-Trent specialist health adult learning disability services will provide high quality care that is transparent with regular reviews of service performance. Quality standards and outcome measures will be clearly identified and utilised at all points of the care pathway as people move through the services from the point of admission to discharge, to ensure all elements of the service are delivering high quality care.

Monitoring of quality and efficacy of services via clinician reported outcome measures is an essential element of service delivery. However it is vital to ensure that equal priority is given to service user experience and feedback. Carer/ service user feedback questionnaires, patient experience surveys and patient stories are just some of the tools available to support this.

In order to support this further, access to advocacy services will be facilitated by all members of the specialist health services / teams as appropriate.

In monitoring the quality of services it is important to recognise the role of local learning disability self- advocacy groups and organisations such as Learning Disability Partnership Boards, Reach and Assist advocacy for individual service users.

To monitor quality at a service level, services will use a range of national and local outcome measures/tools to monitor the quality of the services provided and

delivered. The information provided will then be used to enable regular reporting of performance from local service providers to Commissioners of services. This will then ensure that quality is monitored and maintained. The established NHS contract will also be used to measure service quality, performance and outcomes.

National and local outcome measures/tools such as; 'Key Performance Indicators' (KPI's), 'Health of the Nation Outcome Scales for People with Learning Disabilities' (HONOS LD), 'Care Quality Commission' (CQC), 'Commissioning for Quality and Innovation Framework' (CQUINs) and Health Equalities Framework (HEF) outcomes, will all be part of the process of ensuring that high quality services are provided and that quality is monitored, improved upon and maintained.

In addition future learning disability services are highly likely to be utilising the National Mental Health Clustering Tool, which is a core component of Mental Health Payment by Results (PbR) .In relation to learning disability this tool is still under development and awaiting national agreement.

Local quality monitoring policies and protocols will be agreed between Learning Disability Commissioners and providers of services.

Service design and delivery will be as a result of evidence based practice and models of good practice from other learning disability services nationally.

Involving People with learning disabilities with complex needs and challenging behaviour and their carers.

The effective involvement and engagement of people with learning disabilities with complex needs and challenging behaviour and their carers, will be supported by a robust Communications and Engagement strategy, led and supported by Communications Lead Officers across Staffordshire and Stoke-on-Trent.

Feedback from carer and service users and patient experience/patient stories are tools that help to support people with Learning Disabilities to be part of service development. The provision of service information in an individualised and accessible format is invaluable for both people with learning disabilities and their carers. Local providers of services will utilise these tools as appropriate and in accordance with Trust guidance, along with individual service users 'communication care plans which will detail how that person can effectively and meaningfully engage and communicate, where available.

Local Learning Disability Partnership Boards are part of this process and are included in the 'Communication and Engagement' Strategy. However, due to the communication and engagement difficulties often experienced by people with learning disabilities with the most complex needs and challenging behaviour it will be crucial to involve Independent Advocates too.

The 'Communication and Engagement' strategy identifies that bespoke methods of communication will be required for some individuals and their carers. This will ensure that meaningful attempts are made to involve them and that reasonable adjustments have been made to the communication and engagement process.

Conclusion

The benefits of a coherent service model and agreed service development plan, integrated across health and social care are far reaching.

Future service models will enable people with learning disabilities and their carers, partnership and referring agencies to understand how services are linked and how to access the most appropriate part of the service to meet the identified needs at any given point. This will then ensure that services are delivered that are timely, consistent and person centred and of the highest quality.

This service development plan will help to raise the profile of learning disability services across Staffordshire and Stoke on Trent, within not only health and social care but also with partnership agencies and local providers of services.

Both the service development plan and service model will support and promote inter-agency and multi-disciplinary working that will be evidence based and cost effective.

Appendices

The information detailed below is the Local providers' interpretation of the model of the tiered service model and proposal for developing a new ISS service along with service access criteria.

North Staffs Combined Healthcare NHS Trust (NSCHT)

Learning Disability Service Information

The NSCHT Learning Disability service operates a stepped care model where following receipt of referral and completion of assessment or period of intervention an individual's care may be stepped up to the Learning Disability Intensive Support Service at the time of greatest need and stepped down to a less complex service such as the CLDT and / or primary care when the crisis has been successfully managed.

The services will be accessed by adults who must meet all of the following criteria:-

Aged 18 years and over or transitional arrangements are in place for those aged 17 years and 6 months from their 18th Birthday with a diagnosed Learning Disability.

The presence of a learning disability is not, of itself, sufficient to ensure eligibility for specialist CLDT services. To be eligible, people must also have complex needs that are critical and substantial in nature.

A person is defined as having complex needs if in addition to their learning disability, they present with at least one of the following:

- Additional significant disabilities or impairments such as epilepsy, a physical disability, or autism. Significant mental health problems e.g. a significant mood disorder (including anxiety and depression), complex trauma reaction, schizophrenia, personality disorder or dementia, where their needs cannot be met through mainstream mental health services due to the impact of their learning disability. Vulnerabilities related to risk issues; for example from self-harm, harm from others, neglect or disengagement from services.

- Complex behavioural needs that challenge.

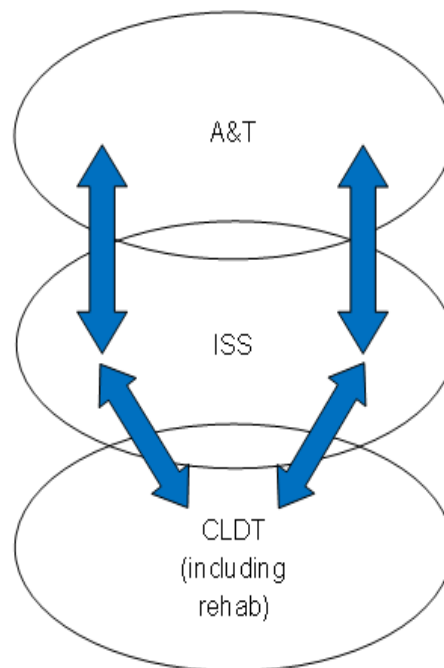
To be eligible for CLDT services, people's complex needs must be critical or substantial in nature. That is, people's difficulties will be having a significant impact on their health, well-being, environment, relationships, opportunities for independence and overall quality of life.

Stepped Care Model

The ISS operates a stepped care model where clients' care is stepped up at the time of greatest need and stepped down to a less complex service such as the CLDT and/or primary care when they are able.

A&T / ISS

The ISS will be the direct 'gatekeeper' for admissions to A&T beds. This is based on the premise that an individual has received input via the ISS but still requires additional support. Alongside this, A&T will be able to refer directly to the ISS to support any difficult transitions for clients pending discharge to promote a smooth transition and prevent a breakdown in the placement. Request for admissions from CLDT will be transferred to the ISS for consideration and further management.



ISS / CLDT / Rehab

The CLDT will be able to refer directly into the ISS to minimise any further deterioration to an individual and prevent admission to Hospital. The intensity of support provided by the ISS will be greater than that provided by the CLDT. Once the crisis period has passed the individual will be re-referred back from the ISS to the CLDT. In addition, the CLDT will manage and 'gatekeep' admissions to the rehab unit, in accordance with the enablement model utilised within the CLDT.

South Staffordshire and Shropshire Healthcare Foundation NHS Trust Learning Disability Service Information

The South Staffordshire and Shropshire Healthcare NHS Foundation Trust's Specialist Community Health Teams for Adults with a Learning Disability (SCHALD) work with adults who have learning disabilities and complex needs and require specialized support from a range of health professionals within the scope of the commissioned service.

Eligibility Criteria: South Staffordshire and Shropshire Healthcare NHS Foundation Trust's Specialist Community Health Teams for Adults with a Learning Disability (SCHALD) work with individuals who have a learning disability and complex health needs requiring specialist support from a range of multidisciplinary health professionals.

To be eligible for this service, people must meet all three of the following criteria:

1. The individual has a learning disability and is over 18 years old.
2. Complex health needs.
3. Difficulties which are critical or substantial in nature that cannot be met via mainstream services.

Complex Health Needs: A person is defined as having complex health needs if in addition to their learning disability, they present with at least one of the following:

- 1) Additional impairments i.e. a physical disability, epilepsy, autism, dementia.
- 2) Mental health problems where their needs cannot be met through mainstream mental health services due to the impact of their learning disability. Mental health problems might include; a mood disorder (including anxiety and depression), complex trauma, schizophrenia, personality disorder and dementia.
- 3) Vulnerability related to risk i.e. self-harm, harm from others, neglect and / or disengagement from services.
- 4) Complex behavioural needs that challenge.

As previously stated, an individual's complex health needs must be critical or substantial in nature in order to be eligible for input from SCHALD. The definitions of critical and substantial are outlined below.

Health difficulties which are critical or substantial in nature: An individual's complex health needs are defined as critical or substantial if they are having a significant impact on their mental and or physical wellbeing, their environment, their relationships, their opportunities for independence and their overall quality of life.

Critical need is identified where there is the presence of:

- A life threatening condition or a threat to life.
- A serious or permanent injury and or harm e.g. scarring.
- A significant impact on physical and / or psychological health.
- A major disruption/s to an individual's involvement, inclusion, environment and relationships.

In addition to one or more of the following:

- An individual has significant health problems or is likely to develop them.
- An individual has, or is unlikely to, have little no choice and control over vital aspects of their immediate environment.
- An individual has suffered abuse or neglect, or is likely to.
- There is, or it is anticipated that, an individual will not be able to carry out the majority of their personal care or domestic routines.
- An individual's vital involvement in work, education or learning cannot, or will not, be sustained.
- The majority of an individual's vital social support systems and relationships cannot, or will not, be sustained.
- The majority of an individual's vital family responsibilities and / or other social roles cannot, or will not, be fulfilled.

Substantial need is identified where there is the presence of:

- Physical harm and / or psychological distress.
- Frequent disruption to an individual's involvement, inclusion, environment and relationships.

In addition to one or more of the following:

- An individual's distress about limited choice and control over their immediate environment.
- Abuse or neglect which has occurred or is deemed likely to occur.
- There is, or it is anticipated that, an individual will not be able to carry out the majority of their personal care or domestic routines.
- An individual's involvement in their employment, education or learning cannot, or is deemed unlikely, to be sustained.
- The majority of an individual's social support systems and relationships cannot, or will not, be sustained.
- The majority of an individual's family responsibilities and / or other social roles cannot, or will not, be fulfilled.

Along with the community teams South Staffordshire and Shropshire Healthcare Foundation NHS Trust provides an inpatient service. Milford House is an inpatient unit consisting of 12 beds for male service users with learning disabilities over the age of 18 years, whose circumstances or care needs are such that it is considered that they are unable to receive treatment and support appropriately in their current environment or an alternative less restrictive care setting.

The unit is purpose built to provide assessment, treatment and/or rehabilitation to men with a diagnosis of a learning disability, who have additional identified complex health care needs, requiring specialist skills interventions.

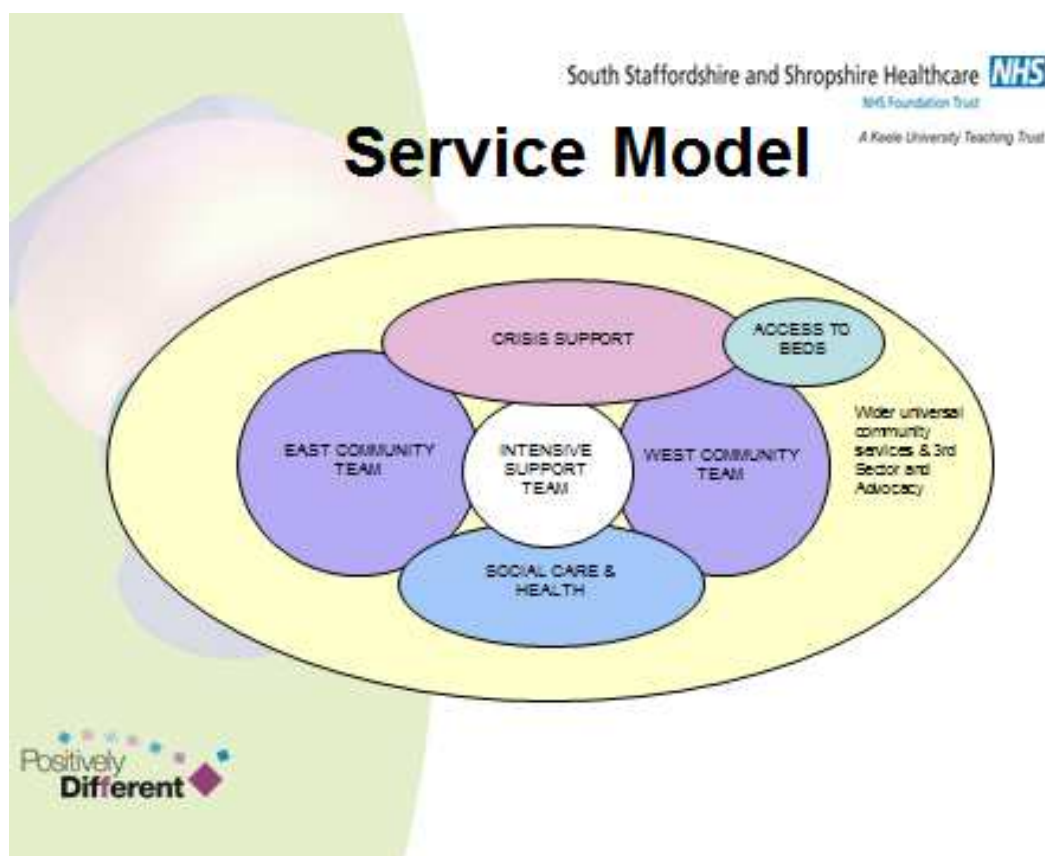
Milford House provides intensive, comprehensive, person centred care, by suitably trained professionals to meet the needs of the service users, which adhering to the Trust values and principles. It provides a multi-professional, research-based service, which aims to assess, treat and evaluate each service user's health and social needs.

Inclusion criteria:

- Men between the age of 18 – 65 years, with an identified learning disability and other associated complex health needs that cannot be met in any other alternative service

This may also include:

- Severe or persistent mental health needs
- Long term disorders of lesser severity but which are characterised by poor compliance to treatment and require proactive interventions and follow up to prevent repeated relapse via a specialist service user review
- Service users who are detained under the Mental Health Act, 1983 (amended 2007)
- Service users who lack capacity and may require a deprivation of liberty under the Mental Capacity Act, 2005 in order to receive appropriate care and treatment for their individual need
- Service users with developmental disorders who require admission to assist them to manage aspects of their condition



Glossary of Terms

Care Quality Commission (CQC)

CQC's role is to ensure that services are meeting national standards also have a role to play in local quality monitoring. The monitoring carried out by CQC is also shared with the public; thus supporting transparency in services.

Clinical Commissioning Group (CCG)

A clinical commissioning group is a new NHS organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services.

As commissioners of local health services, a CCG is responsible for planning the right services to meet the needs of local people, buying local health services including community health care and hospital services, and checking that the services are delivering the best possible care and treatment for those who need them.

A CCG has to work within a local budget from the NHS for local health services and work closely with other NHS colleagues and local authorities to ensure local people are receiving the best possible care.

The Clinical Commissioning Groups are overseen by NHS England (NHS Commissioning Board) which ensures that Clinical Commissioning Groups have the capacity and capability to commission services successfully and to meet their financial responsibilities

Commissioning for Quality and Innovation Framework (CQUINs)

CQUINs is a system that allows commissioners of services to respond to improvements in quality, innovation and excellence. CQUINs encourage care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare. For service users and carers this means a better experience, involvement and outcomes.

'Health of the Nation Outcome Scales for People with Learning' (HONOS LD)

HONOS LD is a clinical outcome measure that measures behaviour, impairment, symptoms and social functioning (Wing, Curtis & Beevor, 1996). This tool is recognized not only for its clinical use but also to be beneficial for care commissioners and providers of services and can be used across a whole service.

Key Performance Indicators (KPI's)

KPIs can be used to evaluate success within services or to evaluate the success of a particular activity in which it is engaged. Success can be simply the repeated, periodic achievement of some level of operational goal (e.g. 10/10 customer satisfaction, etc.). Choosing the right KPIs relies upon a good understanding of what is important to a service such as number of new referrals or improvement on quality of life measure for example.

Service KPI's will be identified against which service provision will be monitored and reported. KPI's will ensure quality standards are set and that performance in relation to service delivery is monitored.

Reasonable Adjustments

The duty to make reasonable adjustments is a legal responsibility under the DDA. It applies to people such as employers, service providers and education providers and is intended to make sure that disabled people do not face substantial difficulties in employment, education or when using services. Failure to make reasonable adjustments can be a form of discrimination and is unlawful.

The Disability Discrimination Act (DDA) defines a reasonable adjustment as a reasonable step taken to prevent a disabled person suffering a substantial disadvantage compared with people who are not disabled. An adjustment, in the context of the DDA, is a change. This can be a physical change or a change in the way something is done.

Removal of discrimination, as required by the D.D.A., requires removing this kind of barrier, not just more obvious or direct discrimination based on disability. Making

changes to ensure equal opportunity for people with a disability is commonly referred to as "reasonable adjustment" or "reasonable accommodation"

Universal services

By universal services we mean the kind of things that are available to all people. These are not accessed through health or social care. These might include services such as housing, transport, leisure and entertainment facilities and employment services. Services that offer advice and information are also included in universal services.

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